STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to promote each resident's right to self-determination when the facility failed to complete showers/bathing to meet resident preferences for two residents (Resident #1 and #2). The facility census was 114.	F 561		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
LNHA 77166	Administrator	3-28-25

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 561	Continued From page 1	F 561		

Review showed the facility did not provide a policy regarding showers/bathing.

1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:

-Admission date of 01/27/24
-Diagnoses included cerebrovascular disease (a group of conditions that affect the blood vessels in the brain, leading to reduced blood flow and oxygen supply to the brain), cellulitis (bacterial skin infection) of left lower leg, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (refers to a condition where a person experiences weakness or paralysis on the left side of their body due to a stroke (cerebral infarction) that damaged the right side of their brain, which controls the left side of the body), adjustment disorder with depressed mood, dizziness and giddiness, muscle weakness, and repeated falls.

Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 12/08/24, showed the following:

-The resident was cognitively intact;
-The resident used a walker and a wheelchair;
-The resident required partial/moderate assistance for showering/bathing.

Review of the resident's care plan, updated 01/31/24, showed the following:

-The resident required one to two assist for all of the resident's activities of daily living (ADL's - dressing, grooming, bathing, eating, and toileting)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

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F 561	Continued From page 2 due to hemiplegia with impaired mobility, weakness, altered vision, medication regimen pain, and disease processes; -The resident will receive the level of care needed to ensure that all needs are met through the review period; -Staff to assist the resident with hygiene measures such as applying deodorant and perfume and brushing air; -Staff to bathe/shower the resident two times a week and assist him/her to maintain good personal hygiene and clean clothes; -Staff to offer resident up to two baths per week, however may resident may refuse or request extra at any time. Review of the resident's shower records showed the following: -On 01/03/25, hospice staff offered the resident a shower. The resident refused; -On 01/07/25, hospice staff provided the resident a shower; -On 01/09/25, hospice staff provided the resident a shower; -On 01/14/25, hospice staff provided the resident a shower (five days after the prior shower); -On 01/21/25, hospice staff offered the resident a shower (seven days after the prior shower). The resident refused -On 01/24/25, hospice staff provided the resident a shower (ten days after the prior shower); -On 01/28/25, hospice staff provided the resident a shower; -On 02/07/25, hospice staff provided the resident a shower (seven days after the prior shower); -On 02/10/25, hospice staff provided the resident a shower; -On 02/17/25, hospice staff provided the resident	F 561		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

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F 561	Continued From page 3	F 561		

a shower (seven days after the prior shower);
-On 02/21/25, hospice staff provided the resident a shower (seven days after the prior shower);
-On 02/25/25, hospice staff provided the resident a shower.

Review of the resident's shower records for January 2025 and February 2025 showed facility staff did not document offering or providing showers to the resident.

During an interview on 02/28/25, at 8:48 A.M., the resident said he/she would like to have more showers. He/she believed that he/she gets around one to two showers a week. He/she knew staff was busy. He/she does not refuse showers unless he/she was having increased pain.

2. Record review of Resident #2's face sheet showed the following:

-Admission date of 01/22/21
-Diagnoses included diabetes type II, anxiety disorder, and muscle weakness.

Review of the residents annual MDS, dated 12/11/24, showed the following:

-The resident was cognitively intact;
-The resident required partial/moderate assistance for showering/bathing.

Review of the resident's care plan, dated 04/29/22, showed the following:

-The resident required supervision/set-up/assist of one to complete ADL's due to impaired mobility, lower extremity weakness, pain, and disease processes;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 4	F 561		

-The resident would receive the level of care needed to ensure that all needs are met through the review period;
-Staff to assist the resident with hygiene measures such as applying deodorant and perfume and brushing air;
-Staff to bathe/shower the resident two times a week and assist him/her to maintain good personal hygiene and clean clothes.;
-The resident is offered two baths per week, however may refuse or request extra at any time;
-Schedule ADL's at a time when he/she is most likely to participate.

Review of the resident's February 2025 shower/bathing records showed the following:

-The resident received a tub bath on 02/14/25 (at least 14 days since prior bath/shower);
-The resident refused a shower on 02/15/25;
-As of 02/28/25, no the shower/bath had been offered/provided for February 2025.

During an interview on 03/27/25, at 10:54 A.M., the resident said the following:

-He/she has not had a shower in about two weeks. He/she would like to have more showers. He/she was supposed to get a shower yesterday, but staff never offered;
-He/she was supposed to get showers every Wednesday and Saturday, but sometimes staff don't offer.

3. During an interview on 02/28/25, at 9:15 A.M., Certified Nurse Aide (CNA) G said the following:

-The resident's are supposed to get showers at least two times a week, but more often if they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

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SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

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F 561	Continued From page 5	F 561		

request it. It is not always happening;
-Sometimes the residents will refuse, but that should be documented. The CNAs fill out a shower sheet and document it in the computer when a shower is completed or they get a refusal.

During an interview on 02/28/25, at 9:23 A.M., Licensed Practical Nurse (LPN) H said showers should be offered to residents at least two times a week. He/she does not know if that was always happening. The showers should be documented on a shower sheet.

During an interview on 02/28/25, at 9:00 A.M., Registered Nurse (RN) F said the CNA's try to give the residents two showers a week or whatever their preference is. It should be documented on a shower sheet.

During an interview on 02/28/25, at 1:36 P.M., MDS Coordinator A said the following:

-The residents should be offered at least two baths/showers a week;
-If the resident has multiple refusals it should be on the care plan and it should be documented in the resident's chart;
-The staff that completes the shower should document that the shower was given.

During an interview on 02/28/25, at 2:14 P.M., MDS Coordinator B said the following:

-Resident refusals/preferences for showers should be put in the care plan;
-Showers should be given two times a week. He/she does now know if the residents are having showers offered two times a week.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

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F 561	Continued From page 6 During an interview on 02/28/25, at 3:04 P.M., the Assistant Director of Nursing (ADON) said the following: -Showers were scheduled for at least twice weekly. He/she thought showers were being completed per the schedule or at resident's request, but didn't think staff were documenting showers appropriately; -Resident refusals should documented in the chart; -He/she was not aware that the facility should be offering showers in addition to what hospice provides; -Staff should document showers on shower sheets and in the electronic medical record. During an interview on 02/27/25, at 3:37 P.M., the Director of Nursing (DON) said the following: -The residents were supposed to be offered at least two showers a week, but staff can provide more if requested; -The resident's are scheduled certain days so that each CNA have around four showers to do a shift; -If a resident is on hospice the resident should be getting at least offered two showers by the facility in addition to what hospice provides, especially if that is the resident's preference; -Resident showers should be documented on shower sheets and in the chart, including, refusals/attempts. During an interview on 02/28/25, at 3:35 P.M., the Administrator said showers are offered one to two times per week. A resident can request showers more frequently or can refuse. Staff should document showers or refusals appropriately.	F 561		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

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F 561	Continued From page 7	F 561		
	MO00247762			
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the maintain residents free from accident hazards when the facility failed to fully document fall events/investigations and to follow, update, develop, and ensure the accuracy of care plans and failed to implement new interventions in attempt to prevent falls consistent with the residents' physical and cognitive abilities for four residents (Residents #1, #3, #4 and #5). The facility census was 114. Review of the facility's policy Fall Prevention Manual, dated 06/2006, showed the following: -Identify all current residents at risk for falls at the beginning of the program using the facility risk assessment form or a chosen form. This should be done by the charge nurse, supervising registered nurse, or interdisciplinary care team (IDT); -Assess all new residents for fall risk on admission using an additional fall assessment screen. The form should be completed within the	F 689		

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	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

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F 689	Continued From page 8 first 12 hours following admission by the admitting nurse, or the oncoming nurse; -Implement a resident orientation program, making social services and nursing accountable for providing information. Orient all new residents to the facility. Concentrate on areas which are of particular importance for the resident based on assessment and resident interview; -Reassess all residents as a part of quarterly assessment and care planning; -The effectiveness of a facility's fall prevention program should be part of continuous quality improvement. Keep a fall log to analyze causes of falls and facility trends or needs. The data in the log may point to variables that are present when falls commonly occur. Review the surveillance fall log to make sure the process is working, and falls are being prevented. Include tracking of falls on new admissions as an indicator of the effectiveness of fall risk assessment and orientation; -Once trends are identified, review the trend for a potential cause for this group of falls (do not assume the cause); implement an action plan based on root cause; set a re-evaluation date to determine how the solution is working; and perform follow-up and document results; -Continue the action, if it is working, or perform additional analysis as to why it is not working and decide on a new action plan for implementation; -Investigate the fall to determine cause; -Log the fall, remove cause of fall, if possible. If cause can't be removed, revise plan to further address risks. 1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:	F 689		

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	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9 -Admission date of 01/27/24 -Diagnoses included cerebrovascular disease (a group of conditions that affect the blood vessels in the brain, leading to reduced blood flow and oxygen supply to the brain), hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (refers to a condition where a person experiences weakness or paralysis on the left side of their body due to a stroke (cerebral infarction) that damaged the right side of their brain, which controls the left side of the body), muscle weakness, and repeated falls. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff),dated 12/08/24, showed the following: -The resident was cognitively intact; -The resident used a walker and a wheelchair; -The resident had two falls since admission with minor injury. Review of the resident's care plan, dated 01/27/24 and updated 01/29/24, showed the following: -The resident was at risk or falls with history of falls prior to admission, impaired mobility/vision, use of tethering equipment, medication regimen, weakness, and disease processes; -Avoid clutter on resident's floor surface; -Avoid unnecessary rearrangement of resident's physical environment; -Complete resident fall assessment quarterly and as needed; -Ensure that resident was positioned appropriately; -Ensure that the resident was wearing	F 689		

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	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10	F 689		

appropriate footwear that fits well, fastened securely, and had nonskid soles;
-If resident had a fall, do an assessment, including vital signs, prior to moving him/her. Notify resident's family and physician. Complete documentation per facility policy protocol;
-Keep call light within reach in his/her room;
-Keep needed items within easy reach;
-Observe for any changes in condition that may warrant increased supervision/assistance and notify his/her physician.

Review of the resident's Fall Risk Assessment, dated 12/09/24, showed staff assessed the resident as a high fall risk.

Review of the resident's nurses' notes dated 01/08/25, at 3:29 P.M., showed Registered Nurse (RN) D said a certified nurse aide (CNA) walked by the resident's room and saw resident lying on the floor on his/her left side. The resident denied pain and no injury noted was noted. The resident was assisted to the wheelchair. The resident was able to stand and bear weight. The call light was in reach and neuro check were started.

Review of the resident's fall event dated 01/08/25, at 3:28 P.M., showed the following:

-The fall was unwitnessed with no injury;
-The fall occurred in the resident's room;
-Staff did not complete the assessment and intervention portion;
-Vital signs were normal
-Staff did not note review of the care plan;
-Physician notified;
-Event observation completed for new fall follow-up, fall prevention program initiated, and care plan updated.

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	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

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F 689	Continued From page 11 Review of the resident's care plan showed staff did not update the care plan with the fall or any new interventions to prevent future falls. Review of the resident's fall event dated 01/13/25, at 8:50 A.M., showed the following: -The fall was witnessed with no injury. Neurological assessments were initiated; -The fall occurred in the resident's room -The fall was unwitnessed. The facility must begin 72 hour neurochecks per protocol and document appropriately; -The resident was ambulating just prior to the fall; -Resident had no pain; -Resident had no injury; -Range of motion was without pain or limitations with no rotation, deformity or shortening noted; -Resident was alert; -Staff did not complete the neurological check section; -Possible contributing factors included resident had a wheelchair present, but was not using it; -Immediate measures taken were none; -Preventative interventions implemented (care plan updated) were shoes with non-skid soles and assist resident to bed if tired; -Outcome of interventions were somewhat effective, describe below (no description given); -Staff noted care plan was not reviewed; -Physician notified; -Event observation completed for new fall follow-up, fall prevention program initiated, and care plan updated. Review of the resident's care plan showed staff did not update the care plan with the fall or any new interventions to prevent future falls.	F 689		

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	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

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F 689	Continued From page 12 Review of the resident's fall event dated 01/23/25, at 8:00 P.M., showed the following: -The resident was observed on the floor with no injury. Neurological assessments were initiated; -The resident was self-transferring to bed; -The fall was unwitnessed and the facility must begin 72 hour neurochecks per protocol and document appropriately; -Resident had pain to the left shoulder; -Resident had no injury; -Range of motion was without pain or limitations with no rotation, deformity or shortening noted; -Resident was alert; -Neurochecks were normal; -Possible contributing factors included cardiac respiratory disease; -Immediate measures taken were none; -Preventative interventions implemented (care plan updated) was monitor; -Outcome of interventions: No interventions used; -Care plan was not reviewed; -Physician notified; -Event observation completed for new fall follow-up, fall prevention program initiated, and care plan updated. Review of the resident's care plan showed on 01/24/25 staff updated the care plan with initiate facility fall protocol. Staff did not update the care plan with recent falls or new interventions. Review of the resident's fall event, dated 02/14/25, showed the following: -The resident was observed on the floor with no injury. Neurological assessments were initiated; -The resident was transferring in the bathroom;	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

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F 689	Continued From page 13	F 689		

-The fall was unwitnessed and the facility must begin 72 hour neurochecks per protocol and document appropriately;
-Resident had no pain;
-Resident has no injury;
-Range of motion was without pain or limitations with no rotation, deformity or shortening noted;
-Resident was alert;
-Neurochecks were normal;
-Possible contributing factors - none of the above;
-Resident takes analgesics and antihypertensives;
-Immediate measures taken - none;
-Preventative interventions implemented (care plan updated updated), shoes with non-skid shoes;
-Outcome of interventions. Interventions somewhat effective, describe below (there was no description given);
-Care plan was not reviewed;
-Physician not notified;
-Vital signs taken;
-Event observation completed for new fall follow-up, fall prevention program initiated, and care plan updated.

Review of the resident's care plan showed staff did not update the care plan with the fall or new interventions to prevent future falls.

Review of the resident's fall event, dated 02/16/25, showed the following:

-The resident was observed on the floor with a gash to the back of the head. Neurological assessments were initiated;
-The fall was unwitnessed and the facility must begin 72 hour neurochecks per protocol and document appropriately;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14 -Resident had mild (2/10) pain on the back of the left side of head and left shoulder; -The resident had an abrasion/laceration; -Range of motion was without pain or limitations with no rotation, deformity or shortening noted; -Resident was alert; -Neurochecks were normal; -Possible contributing factors - cardiac/respiratory disease; -Resident takes analgesics and antihypertensives; -Immediate measures taken - direct pressure to wound; -Preventative interventions implemented (care plan updated updated) - monitor frequently; -No interventions used; -Physician and next of kin notified; -Order received for resident to be sent to the hospital for evaluation and treatment. Review of the resident's nursing notes showed the following: -On 02/16/25, at 2:00 A.M., showed Licensed Practical Nurse (LPN) noted at 12:35 A.M., the staff heard a thud and went to the resident's room. The resident was observed laying on the floor in front of the sink on the left side. There was bleeding from the left side of the back of his/her head. There was a laceration to the left side of the back of the head. It was approximately 1 ½ inches long. A pressure dressing was applied. Neuro checks within normal limits. Range of motion (ROM) was assessed. The resident was assisted up with two person assistance to bed. The resident had walked to the sink with the walker. The physician was notified at 12:42 A.M. and orders were received to send the resident to the hospital for evaluation and	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

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F 689	Continued From page 15	F 689		

treatment. Attempts were made to reach the resident's family. At 12:50 A.M., hospice was notified. At 12:55 A.M., the ambulance arrived and resident was transferred to the hospital at 1:20 A.M.
Review of the resident's nursing notes, showed the following:
-On 02/17/25, at 12:36 A.M., LPN A noted the resident continued on fall monitoring for recent fall. The staples were intact to the back of the head. Neuro checks are within normal limits for the resident. Resident was resting quietly;
-On 02/17/25, at 11:30 P.M., Registered Nurse (RN) B noted the resident was on fall follow up for unwitnessed fall with injury. Neuro checks are unchanged from baseline. The staples were intact to wound on the back of the head. The residents said it was sore. The resident was re-educated on the need to call for assistance prior to getting up. Staff will continue to monitor;

Review of the resident's care plan showed staff did not update the care plan with the fall or new interventions to prevent future falls.

During an interview on 02/28/25, at 8:48 A.M., the resident said the following:

-He/she had multiple falls at the facility;
-The last fall happened due to wearing slippers that were slippery on the bottom. He/she cut his/her head open when he/she fell.

Observations on 02/28/25, at 8:48 A.M. and 2:40 P.M. showed the resident's door frame did not show a leaf that staff used to designate that the resident was at risk of falls.
2. Review of Resident #3's face sheet showed the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16 -Admission date of 12/30/24; -Diagnoses included cognitive communication deficit, muscle weakness, osteoarthritis, low back pain, abnormality of gait and mobility, insomnia, and left hip fracture. Review of the resident's care plan, dated on 12/30/24, showed the following: -Resident at risk for falls related to altered cognition and impaired mobility; -Staff to keep call light in reach, monitor for any change in condition, provide standby assistance for mobility, complete my fall risk assessment quarterly and as needed, and ensure appropriate footwear that fits well, fastens securely, and has nonskid soles. Review of the resident's fall event report, dated 01/04/25, showed the resident had an unwitnessed fall. Resident was observed on floor with possible injury to the left hip. Staff began neuro checks and completed full assessment. Resident complained of moderate pain to left hip. Review of the resident's nurses' notes showed staff documented the following: -On 01/04/25, at 11:05 P.M., resident was found on the floor on his/her back. Resident complained of left hip pain. Physician ordered on-site x-ray and mobile x-ray unable to respond until 8:00 A.M. Physician was made aware; -On 01/05/25, staff noted x-ray negative. Review of the resident's care plan showed staff did not update the care plan with the fall or new interventions to prevent future falls.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 17	F 689		

Review of the resident's admission MDS, dated 01/06/25, showed the following information:

-Resident had moderately impaired cognition;
-Resident dependent on assistance for wheelchair mobilization, dressing, personal hygiene, bed mobility, standing from sitting, and bed/chair transfers;
-Ambulation did not occur during the 7-day look back period.

Review of the resident's fall event report, dated 01/16/25, showed the following:

-An unwitnessed fall with injuries and skin tears to left forehead and left wrist;
-Staff began 72-hour neurochecks per protocol and to document appropriately;
-Staff document full assessment documented and complaint of left leg pain;
-Interventions immediate measures of first aid. Preventative interventions of encouraged to use call light for assistance;
-Outcome of interventions: no interventions used, resident in bed resting at this time.

Review of the resident's nurses' notes showed staff documented the following:

-On 01/16/25, at 12:55 A.M., resident was alert and oriented to person and place with periods of confusion and restless at times and easily redirected;
-On 01/16/25 at 10:05 P.M., aide reported a fall. Nurse observed resident lying down on his/her left side with skin tears to forehead that measured 0.4 centimeters (cm) and left wrist 1.0 cm. Resident complained of pain and was unable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 18	F 689		

to tell staff what happened. Staff obtained order for x-ray in the morning. Staff will continue to monitor;
-On 01/17/25, at 12:05 A.M., resident alert to person and place with periods of confusion, trying to get out of bed without assistance. Resident required total assist with cares and used wheelchair for mobility;
-On 01/17/25, at 9:23 A.M., resident noted to have left hip fracture related to fall on 01/16/25 that was confirmed by mobile x-ray. Family advised and physician advised of results. Resident sent to hospital at 9:10 A.M. for evaluation and treatment.

Review of the resident's care plan showed staff did not update the care plan with the fall or new interventions to prevent future falls.

3. Review of Resident #4's face sheet showed the following:

-Admission date of 12/31/24;
-Diagnoses included arthritis, osteoporosis, left pubic fracture (on admission), insomnia, restlessness and agitation, hallucinations, repeated falls (on admission), osteoarthritis to right shoulder, and chronic pain.

Review of the resident's admission MDS, dated 01/07/25, showed the following information:

-Resident had moderate to severely impaired cognition;
-Resident required partial to moderate assistance for toileting hygiene and upper body dressing;
-Resident required substantial to maximal assistance for bed mobility, standing from sitting, bed/chair transfers, and ambulation of 10 feet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 19	F 689		

Review of the resident's care plan, dated 12/31/24, showed the following:

-Resident at risk for falls related to history of falls, altered cognition, impaired mobility, medication regimen, general debility, and disease processes;
-Staff to avoid clutter on floor surface, complete fall risk assessment quarterly and as needed, ensure appropriate footwear that fits well, fastens securely, and has nonskid soles, and place a fall mat next to the bed.

Review of the resident's fall event report, entered 01/01/25 at 1:16 A.M., showed the following:

-Event date of 12/31/24 at 6:30 P.M.;
-Resident found lying in floor next to bed;
-Unwitnessed fall. Staff began 72-hour neurochecks per protocol and to document appropriately;
-Full assessment documented with no injuries noted and resident denied pain. Resident exhibited agitation, anxiety, and confusion;
-Resident placed at nurses' station for monitoring;
-Falls Prevention Program initiated and care plan updated.

Review of the resident's fall event report, entered 01/01/25 at 1:44 A.M., showed the following:

-Event date of 12/31/25 at 8:00 P.M.;
-Resident found by staff lying in floor of room next to bed;
-Interventions was left blank;
-No injuries noted;
-Vital signs documented;
-Falls Prevention Program initiated and care plan updated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 20 Review of the resident's fall event report, entered 01/01/25 at 2:41 A.M., showed the following: -Event date of 01/01/25 at 1:00 A.M.; -Resident found lying in floor of room next to bed and stated, "I had to help my roommate. Resident had placed roommate in chair; -Interventions were left blank; -Resident refused vital signs and full assessment; -Falls Prevention Program initiated and care plan updated. Review of the resident's fall event report, entered on 01/01/25 at 5:57 A.M., showed the following: -Event date of 01/01/25 at 5:57 A.M.; -Resident found lying in floor next to bed and unable to state what happened; -Unwitnessed fall and staff began 72-hour neurochecks per protocol and to document appropriately; -No injuries noted and resident denied pain; -Interventions of other and left blank. Outcome of interventions noted no interventions used; -Falls Prevention Program initiated and care plan updated. Review of the resident's nurses' notes showed staff documented the following: -On 12/31/24, at 6:30 P.M., resident found by staff lying in floor of room next to bed and unable to say what occurred. Staff noted no injuries and placed resident back in bed. Staff informed physician and family; -On 12/31/24, at 8:00 P.M., resident found by staff lying in floor next to bed and unable to say what occurred. Staff noted no injuries and placed	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 21	F 689		

resident in wheelchair and brought to nurses' station for observation. Staff informed physician and family;
-On 01/01/25, at 1:00 A.M., resident found on floor next to bed. Resident stated he/she had to help his/her roommate and had gotten roommate up to wheelchair. Resident refused vital signs and full assessment. Resident placed in wheelchair and sat by nurses' station for monitoring;
-On 01/01/25, at 5:52 A.M., resident found lying on floor of room next to bed and unable to state what occurred. Staff noted no injuries noted and placed resident back in bed. Staff informed family of all falls and physician to be notified by day shift;
-On 01/01/25, at 5:59 A.M., resident found lying in floor of room next to bed with no injuries noted. Resident refused assessment and staff informed family informed;
-On 01/01/25, at 6:13 A.M., staff informed Assistant Director of Nursing (ADON) of all falls.

Review of the resident's care plan showed staff did not update the care plan with the falls or new interventions to prevent future falls.

Review of the resident's fall event report, entered on 01/07/25 at 2:52 P.M., showed the following:

-Event date of 01/07/25 at 2:51 P.M.;
-Resident found on floor beside his/her bed;
-The fall was unwitnessed fall and staff begin 72-hour neurochecks per protocol and to document appropriately;
-Resident had bruising/hematoma with no location noted;
-Interventions included rest, fall mat placed, and use of relaxation techniques such as white noise, soothing music, fish tank;
-Outcome of interventions were somewhat

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 22	F 689		

effective;
-Falls Prevention Program initiated and care plan updated.

Review of the resident's nurse's note dated 01/08/25, at 12:57 A.M., showed the resident continued on fall monitoring and had a bruise to right side of face from previous fall. Vital signs and range of motion (ROM) within normal limits (WNL) to baseline. Resident did not complain of pain or discomfort. Staff will continue to monitor.

Review of the resident's care plan showed staff did not update the care plan with the fall or new interventions to prevent future falls.

Review of the resident's fall event report, entered on 01/10/25 at 1:57 P.M., showed the following:

-Event date of 01/09/25 at 7:45 P.M.;
-Observed resident on floor beside bed with no injury noted and neurochecks initiated;
-Resident had dozed off. Resident assisted up with two assist. Resident stated that he/she was "trying to get into bed, but didn't quite make it." Neuros initiated and baseline for resident. Resident with advanced dementia and no retention to educate. Vital signs stable. Staff assisted to bed with bed in low position and mat beside bed.
-Fall was unwitnessed and staff began 72-hour neurochecks per protocol and to document appropriately;
-Mental status of confusion and sleepiness;
-Possible contributing factors included recent decline in ADLs (activities of daily living) abilities and dementia;
-Resident on antipsychotics and anti-anxiety medications;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 23 -Interventions of fall mat placed, ensure necessary items are in reach, and assist resident to bed when tired were somewhat effective; -Falls Prevention Program initiated and care plan updated. Review of the resident's nurse's notes showed a late entry dated 01/10/25, at 2:04 A.M., for 01/09/25 at 7:59 P.M. Resident observed lying on floor beside bed. Resident had dozed off. Staff assisted resident up with two assist. Resident stated that he/she was "trying to get into bed, but didn't quite make it." Neuros initiated and baseline for resident. Resident with advanced dementia and no retention to educate. Vital signs stable. Staff assisted to bed with bed in low position and mat beside bed. Review of the resident's care plan showed staff did not update the care plan with the fall or new interventions to prevent future falls. Review of the resident's fall event report, entered on 01/10/25 at 2:03 P.M., showed the following: -Event date of 01/10/25 at 2:00 P.M.; -Observed on the floor at the foot of his/her bed with no injury and neurochecks initiated; -Resident stated he/she went to get up to put him/herself to bed and slipped and fell. Resident denied pain or discomfort; -Fall was unwitnessed fall and staff began 72-hour neurochecks per protocol and to document appropriately; -No changes in mental status; -Interventions noted to ensure necessary items are in reach and assist resident to bed when tired; -Falls Prevention Program initiated and care plan	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 24	F 689		

updated.

Review of the resident's nurse's note dated 01/10/25, at 2:08 P.M., showed the resident was observed lying on the floor at the foot of his/her bed. Resident stated that he/she went to get up to put him/herself to bed and slipped and fell. Resident denied any pain or discomfort and had full range of motion (FROM). Neurochecks initiated and at baseline for resident. Staff notified physician and family.

Review of the resident's care plan showed staff did not update the care plan with the fall or new interventions to prevent future falls.

Review of the resident's fall event report, entered on 01/14/25 at 5:54 P.M., showed the following:

-Event date of 01/14/25 at 12:00 P.M.;
-Witnessed fall with no injury;
-Interventions of non-slip socks;
-Falls Prevention Program initiated and care plan updated.

Review of the resident's care plan showed staff did not update the care plan with the fall or new interventions to prevent future falls.

Review of the resident's fall event report, entered on 02/09/25 at 11:57 A.M., showed the following:

-Event date of 02/09/25 at 10:00 A.M.;
-Resident was heard to yell out. Upon entering room staff observed resident sitting on the floor. Resident stated he/she was trying to go to the bathroom and slipped and fell. Brief noted on the floor with a puddle under resident's feet. Resident had a small laceration to back of head

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 25	F 689		

and right elbow. Area to back of the head cleaned with wound cleanser and covered with one steri-strip. Resident denied pain and neurochecks initiated;
-Fall was unwitnessed fall and staff began 72-hour neurochecks per protocol and to document appropriately;
-No change in mental status;
-Immediate intervention of first aid;
-Falls Prevention Program initiated and care plan updated.

Review of the resident's nurse's note dated 02/09/25, at 10:10 A.M., showed resident was heard to yell out. Upon entering room resident was observed sitting on the floor. Resident stated he/she was trying to go to the bathroom and had slipped and fell. Brief noted on the floor with a puddle under resident's feet. Resident had small laceration to back of head and right elbow. Area to back of the head cleaned with wound cleanser and pressure applied until bleeding stopped. Area to right elbow cleansed with wound cleanser and covered with one steri-strip. Resident denied any pain or discomfort. FROM to all extremities. Resident assisted up via two staff members. Staff initiated neuros and at baseline for resident. Staff notified physician and family.

Review of the resident's care plan showed staff did not update the care plan with the fall or new interventions to prevent future falls.

Review of the resident's fall event report, entered on 02/23/25 at 10:04 A.M., showed the following:

-Event date of 02/23/25 at 6:30 A.M.;
-Fall was witnessed. Resident was sitting at the nurses' desk and stood up out of her wheelchair,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	**1100 EAST MONTCLAIR SPRINGFIELD, MO 65807**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 26	F 689		

slipped on the floor, fell, and hit her head on the counter with no injuries noted. Staff completed full assessment and neurochecks initiated. Staff will continue to monitor.

Review of the resident's nurse's note dated 02/23/25. at 6:30 A.M., resident was sitting at the nurses' desk and stood up out of her wheelchair, slipped on the floor, fell, and hit her head on the counter with no injuries noted. Resident had FROM to all extremities. Resident assisted up via two staff members. Staff initiated neuros and resident at baseline for resident. Staff notified physician and family.

Review of the resident's care plan showed staff did not update the care plan with the fall or new interventions to prevent future falls.

Observation on 02/27/25, at 9:30 A.M., showed the resident rested in bed that was was in the lowest position. A wheelchair was positioned close to the bed. A fall mat was folded in half and was standing on edge at the foot of the bed.

Observation on 02/27/25, at 10:56 A.M., showed the resident rested in bed with his/her eyes closed. A fall mat was fold up and positioned at the foot of the bed.

Observation on 02/28/24, at 2:15 P.M., showed the resident rested on his/her bed. A wheelchair was positioned close to the bed with wheels locked and a fall mat was folded up close to the vacant bed across the room. The resident's doorframe did not have a maple leaf magnet attached to it.

4. Review of Resident #5's face sheet showed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 27	F 689		

following:

-Admission date of 04/15/24;
-Diagnoses included Alzheimer's disease with late onset, dementia, delusions, history of repeated falls, and difficulty with near vision.

Review of the resident's quarterly MDS, dated 01/12/25, showed the following:

-Severely impaired cognition;
-No ambulation and used manual wheelchair, assisted by staff;
-Dependent on others for eating, hygiene/bathing, dressing, sitting/lying/ sitting/standing, and chair/bed transfers;
-No functional limitation on upper or lower extremities;
-Falls since prior assessment (quarterly (dated 10/16/24)) were two without injury, two with minor skin injury, and none with major injury.

Review of the resident's significant change MDS assessment, dated 01/26/25, showed the following;

-Severely impaired cognition;
-No ambulation, manual wheelchair assisted by staff;
-Dependent on others for eating, hygiene/bathing, dressing, sitting/lying, sitting/standing, and chair/bed transfers;
-No functional limitation on upper or lower extremities;
-No falls since prior assessment.

Review of the resident's care plan, initiated on 04/15/24 and last reviewed/revised 01/29/25, showed the following;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

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F 689	Continued From page 28	F 689		

-Resident required assist of one to two staff for ADLs related to severe cognitive loss, impaired mobility, weakness, and disease processes;
-Resident preferred to be in the floor at times and this was a long-term habit;
-Resident up daily to a wheelchair via one to two assist and required assistance for locomotion;
-Resident at risk for falls related to history of falls, impaired safety awareness, impaired mobility, medication regimen, general debility, and disease processes;
-Resident slept on mattress in the floor to ensure safety and was personal preference to sleep in the floor;
-Initiate facility fall protocol;
-Avoid clutter on the floor surface;
-Complete a fall risk assessment quarterly and as needed;
-Ensure resident wears appropriate footwear that fits well, fasten securely, and has non-skid soles;
-If resident falls, do an assessment, including vital signs, prior to moving.

Review of the resident's fall event report, entered on 12/01/24 at 5:46 P.M., showed the following:

-Event date of 12/01/24;
-Witness stated resident was rocking in wheelchair, pushing table, and suddenly slid out of wheelchair onto floor. Witness stated resident did not hit head. Resident agitated and appeared anxious. Certified medication technician (CMT) to give resident medication for anxiety. Staff assisted resident assisted up into wheelchair and placed at table to eat dinner. Staff Will continue to monitor;
-No pain reported and no injury noted;
-Immediate interventions of none. Preventative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 29	F 689		

interventions of fall mat placed and shoes with non-skid soles;
-Falls Prevention Program initiated and care plan updated.

Review of the resident's nurse's note, dated 12/01/24, showed witness stated resident was rocking in wheelchair, pushing table, and suddenly slid out of wheelchair onto floor. Witness stated resident did not hit head. Resident agitated and appears anxious. CMT to give resident anxiety medication. Staff assisted resident up into wheelchair and placed at table to eat dinner. Staff will continue to monitor.

Review of the resident's care plan showed staff did not update the care plan with the fall or new interventions to prevent future falls.

Review of the resident's fall event report, entered on 12/08/24 at 2:52 P.M., showed the following:

-Event date of 12/08/24;
-Resident observed on floor in hallway following his/her attempting to stand up from his/her wheelchair. Resident sustained no visible injury. Extremities all move within normal limits for resident. There was no shortness, rotation, or deformation noted in any extremity. Neuros initiated and are within resident's baseline. Following assessment resident was assisted to standing position with assist of two staff and placed back in wheelchair. Staff attempted notification to durable power of attorney (DPOA) and phone not working. Staff notified physician and received no new orders. Staff will continue with ongoing monitoring;.
-No pain reported and no injury noted;
-No mental changes;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 30 -No interventions; -Care plan not reviewed; -Falls Prevention Program initiated and care plan updated. Review of the resident's nurse's note, dated 12/08/24 at 2:53 P.M., showed resident observed on floor in hallway following his/her attempting to stand up from his/her wheelchair. Resident sustained no visible injury. Extremities all move within normal limits for resident. There was no shortness, rotation or deformation noted in any extremity. Neuros initiated and were within resident's baseline. Following assessment resident was assisted to standing position with assist of two staff and placed back in wheelchair. Staff attempted notification to DPOA and phone not working at this time. Staff notified physician notified with no new orders received. Staff will continue with ongoing monitoring. Review of the resident's care plan showed staff did not update the care plan with the fall or new interventions to prevent future falls. Review of the resident's fall event report, entered on 12/10/24 at 4:13 P.M., showed the following: -Event date of 12/10/24; -No pain reported and no injury noted; -No immediate interventions and preventative interventions implemented and care plan updated - other, describe below; -Describe other measures, if necessary: (left blank); -Care plan not reviewed; -Outcome of interventions was ineffective, describe below; -Describe outcome of interventions: (left blank);	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 31 -Falls Prevention Program initiated and care plan updated. Review of the resident's nurse's note dated 12/10/24, at 4:09 P.M., showed resident witnessed attempting to stand and falling to the floor in the process. Resident did not strike head. Resident without complaint or expression of pain. Resident without any obvious deformity or shortening of limbs. Resident noted at baseline for ROM. Vital signs within normal limits. Staff assisted resident back into wheelchair with two assist. Staff notified physician, responsible party, and DON. Review of the resident's care plan showed staff did not update the care plan with the fall or new interventions to prevent future falls. Review of the resident's fall event report, entered on 12/18/24 at 6:24 A.M., showed the following: -Event date of 12/18/24; -Resident sitting nurses' station and fell out of wheelchair onto right side. A skin tear of 0.5 cm noted to right elbow. Staff applied dressing; -Unwitnessed fall and staff must begin 72-hour neurochecks per protocol and document appropriately; -No pain reported and no injury noted; -No immediate interventions. Preventative interventions implemented (care plan updated) - adjust bed to lowest level, fall mat placed, shoes with non-skid soles, and assist resident to bed when tired; -Care plan not reviewed; -Outcome of interventions was effective; -Falls Prevention Program initiated and care plan updated.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 32	F 689		

Review of the resident's nurse's note dated 12/18/24, at 6:24 A.M., showed resident was sitting behind nurses' station in his/her wheelchair when he/she attempted to stand up, resulting in falling to the floor. Event was witness by staff. Small skin tear noted to the left elbow with no other injury noted at this time. Resident was assisted to standing position and placed back in wheelchair. Neuros not initiated due to resident not hitting head. Physician and responsible party to be notified by oncoming nurse. Staff will continue with ongoing monitoring and nurse on duty informed.

Review of the resident's care plan showed staff did not update the care plan with the fall or new interventions to prevent future falls.

Review of the resident's fall event report, dated 12/19/24, showed the following:

-Event date of 12/19/24;
-Observed on floor, neuros initiated, bruising and raised area to the left side of face;
-Unwitnessed fall and staff must begin 72-hour neurochecks per protocol and document appropriately;
-No pain reported;
-Injury of bruising, bump;
-No change in mental status;
-Immediate intervention of rest and preventative interventions implemented of other, describe below;
-Describe other measures: (left blank);
-Outcome of interventions: no interventions used;
-Notifications made: (none indicated);
-Care plan not reviewed;
-Falls Prevention Program initiated and care plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 33	F 689		

updated.

Review of the resident's nurse's note dated 12/19/24, at 10:39 A.M., showed resident was standing at the desk and lost his/her balance, falling and hitting the left side of his/her head/face on the floor. Resident denied pain at this time and neuros initiated. Vitals have been recorded within normal limits. Staff notified DON and called family who did not answer.

Review of the resident's care plan showed staff did not update the care plan with the fall or new interventions to prevent future falls.

Review of the resident's fall event report, entered on 12/22/24 at 3:23 P.M., showed the following:

-Event date of 12/22/24;
-Unwitnessed fall on 12/22/24, in the hallway;
-Resident was sitting in wheelchair at nurses' station;
-Unwitnessed fall, staff must begin 72-hour neurochecks per protocol and document appropriately;
-No pain reported;
-Injury of bump to left side of forehead and rub burn;
-Mental status of anxiety, confusion, and restlessness;
-Immediate interventions of rest and preventative interventions implemented of assist resident to bed when tired;
-Outcome of interventions noted as effective;
-Care plan not reviewed;
-Falls Prevention Program initiated and care plan updated.

Review of the resident's care plan showed staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 34	F 689		

did not update the care plan with the fall or new interventions to prevent future falls.

Review of the resident's nurse's note dated 02/24/25, at 11:05 A.M., showed resident sitting behind nurses' desk and slid out of chair onto floor in front of medication room door. Staff unable to stop resident from having fall. Incident witnessed by staff. ROM within normal limits for resident and no injuries noted at this time. Staff notified physician and responsible party. Staff assisted resident from floor with two staff and placed back in wheelchair.

Review of the resident's fall event reports showed no entry pertaining to the fall on 02/24/25.

Review of the resident's care plan showed staff did not update the care plan with the fall or new interventions to prevent future falls.

Review of the resident's quarterly Evaluation Notes, documented by MDS Coordinator B, showed the following:

-Quarterly falls from 02/21/24 - 06/19/24: 15 falls; 7 with injury, 8 without injury; interventions reviewed and appropriate;
-Quarterly falls from 06/20/24 to 09/04/24: 1 fall with no injury, 3 falls with injury; interventions reviewed and appropriate; will continue plan of care;
-Quarterly falls from 09/05/24 to 12/13/24: 16 falls - 12 falls with no injury, 4 falls with injury; interventions reviewed and appropriate; will continue plan of care.

Observation on 02/27/25, at 10:35 A.M., showed the resident rested in bed, which was positioned

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 35	F 689		

low to the floor. A thick fall mat was positioned close to the bed and a rubber type mat was positioned lengthwise from the fall mat toward the sink and vanity area of the room.

Observation on 02/27/25, at 10:54 A.M., showed the resident called out with a loud noise and no words were used. A CNA and the facility Administrator both entered the room to respond. The Administrator told the surveyor the resident's care plan indicated the resident would crawl out of bed onto the fall mat, and would crawl and scoot around on the floor, but didn't ever go too far from his/her bed. The mats were in place to protect him/her from falls and from hurting his/her knees.

Observation on 02/28/25, at 2:14 P.M., showed a maple leaf magnet on the top left side of the resident's doorframe.

5. During an interview on 02/28/25, at 2:17 P.M. CNA J said he/she did not know why there was a leaf on some residents' doors. The CNA was unaware of the Falling Leaf Program.

During an interview on 02/28/25, at 9:15 A.M., CNA G said the following:

-He/she gets the nurse if a resident has a fall. The nurse assesses the resident;
-He/she helps by getting vitals signs and will assist with getting the resident up;
-Generally, he/she will then turn the television on or put resident into bed depending on why the resident fell;
-He/she was generally made aware if a resident had a fall by what is passed on in report;
-He/she was not aware of the falling leaf program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 36	F 689		

He/she was not aware of anything marking the door frame of residents that have had falls or are a high fall risk;
-Resident's that have interventions for falls should have it on their care plan. The nurse should pass on any interventions to the staff.

During an interview on 02/28/25, at 9:36 A.M., CNA I said the following:

-He/she was not aware of what the falling leaf program was;
-If a resident falls he/she goes to get the nurse;
-The resident was assessed and he/she assisted with getting vital signs;
-Generally, he/she was told about new falls and interventions in report;
-He/she thought fall interventions should be on the care plan.

During an interview on 02/28/25, at 2:18 P.M., Hospitality Aide (HA) K said he/she did not know why there was a leaf on some residents' doors. The HA was unaware of the Falling Leaf Program.

During an interview on 02/28/25, at 2:20 P.M., CMT L said the leaf magnet on a resident's door means they are a fall risk and staff should monitor them more often.

During an interview on 02/28/25, at 9:23 A.M., LPN H said the following:

-The residents are assessed after a fall by the nurse and the nurse then will provide immediate interventions of pain medication or first aide if needed. The physician is notified immediately if there is injury or suspected injury;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 37 -The staff generally keep a close eye on the residents after they fall; -He/she was not aware of there being anything on the resident's doorways that lets staff know they are a high falls risk, but it is generally passed on in report. He/she was not aware of the falling leaf program; -He/she believed the facility fall protocol was regarding completing an event and fall follow up assessments for 72 hours; -The DON decided on further interventions; -The interventions for falls should be added to the residents' care plans. During an interview on 02/28/25, at 9:00 A.M., RN F said the following: -He/she was not sure what the exact policy and procedure was after a resident falls; -He/she was not sure what the falling leaf program was; -He/she assesses the resident after a fall. The nurse fills out the event and continues monitoring for 72 hours once per shift; -Fall prevention depends on the mechanism of the fall; -He/she thought the fall would be investigated and then interventions should be added to the care plan; -He/she was not sure who adds the interventions to the care plan. During an interview on 02/28/25, at 1:36 P.M., MDS Coordinator N said the following: -Resident care plans are updated with each fall quarterly. New interventions should be added to the care plan; -He/she did not update the care plan after each	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 38	F 689		

fall;
-The intervention depended on what the reason was for the fall;
-If a resident had repeated falls they should be on the falling leaf program;
-The DON puts leaves up on the doorway of residents who have had multiple falls so that staff is aware and checks on them more often;
-They put that on the care plan as the fall protocol;
-The nurses do not update the care plan with interventions;
-The staff discussed falls at the morning meeting and weekly for residents at risk;
-He/she kept putting in interventions for falls until they felt like they are maxed out.

During an interview on 02/28/25, at 2:14 P.M., MDS Coordinator O said the following:

-The care plans were updated quarterly regarding falls;
-The facility had started the falling leaf program. It was on the care plan as the facility fall protocol. The staff put a leaf on the top of the door frame to alert the staff to the resident being a high falls risk and watch the resident closer.

During an interview on 02/28/25, at 3:04 P.M., the Assistant Director of Nursing (ADON) said the following:

-Residents are assessed by the nurse after a fall. The nurse completes the event form and 72 hour fall monitoring;
-Every day resident falls are discussed in the morning meeting, but there is only so many interventions that can be put into place;
-There should be new interventions added to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 39	F 689		

care plan for falls, but he/she was not sure if it updated after every fall;
-If a resident was having multiple falls they are placed on the falling leaf program that is designated with a leaf above the door;
-The falling leaf program was used to make staff aware of the residents that frequently fall;
-The staff are to check on these residents anytime they pass their room;
-The staff should be educated about the falling leaf program;
-The staff should be made aware of new interventions during shift change.

During an interview on 02/27/25, at 3:37 P.M., the DON said the following:

-He/she discussed falls every day during huddle and staff come up with interventions if someone is having multiple falls;
-They have started a falling leaf program. This is also called the facility fall protocol. They place a leaf above the door so that staff will be aware that the person is a high fall risk and staff should check on them more often. The staff have been educated about the program;
-Residents that have multiple falls should have new interventions be added to the care planned;
-The nurse should to fill out a fall event after each fall and complete a full assessment;
-The nurse should document what caused the fall and any pertinent details;
-There should be fall follow up documented for 72 hours.

During an interview on 02/28/25, at 3:35 P.M., the Administrator said the following:

-The facility had daily risk meetings to discuss

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 40 residents that have had falls and to try to set up new interventions; -They try 15-minute checks on some residents or sitting them at the nurses station; -New interventions should be added to the care plan as soon as it is decided; -The MDS coordinator generally adds the new interventions; -They started the falling leaf program about a month ago. There should be a leaf above their doorway to help staff be aware of who has falls. MO00247762	F 689		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05280	A. BUILDING: _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD VILLA	1100 EAST MONTCLAIR SPRINGFIELD, MO 65807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4074	19 CSR 30-85.042(65) Protective Oversight, Voluntary Leave Each resident shall receive twenty-four- (24-) hour protective oversight and supervision. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Class II 1. Please refer to F689. MO00247762	A4074		
A4077	19 CSR 30-85.042(68) Res Groomed/Dressed Appropriately Taking into consideration the resident's preferences, residents shall be well-groomed and dressed appropriately for the time of day, the environment and any identified medical conditions. II/III This regulation is not met as evidenced by: Class II* 1. Please refer to F561. MO00247762 *The higher classification merited due to the extent of the violation.	A4077		

PLAN OF CORRECTION

Provider/Supplier Name:	Springfield Villa
Street Address, City, Zip:	1100 E Montclair, Springfield MO 65807
Date of Survey:	2/28/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This Plan of Correction (POC) is submitted as required under State and Federal law. The Submission of this POC does not constitute as admission on the part of Springfield Villa (the Facility) as to the accuracy of the state surveyor's findings, nor the conclusions drawn there from. The facility's submission of this POC does not constitute an admission on the part of the Facility that the findings cited are accurate, that the scope and severity regarding the deficiencies cited are correctly applied. This POC is intended to constitute the Facility's credible letter alleging compliance. Compliance has been and will be achieved no later than the last completion date identified in the Plan of Correction. Compliance will be maintained as provided in the plan of Correction on 4/8/2025.	Completed on 4/8/25 and ongoing
A4074	In accordance to 19 CSR 30-85.042(65) Protective oversite,	4/10/2025
F 689	Voluntary Leave: Subset 483.25D Free of Accident Hazards/Supervision/	
	483.25D (2) Each resident received adequate supervision and assistance devises to prevent accidents.	
	The facility was found that requirements were not met due to the	
	Facility not fully documenting fall events/investigations and to follow, update, develop, and ensure the accuracy of care plans and failed to implement new interventions in attempt to prevent falls consistent with the residents physical and cognitive abilities for residents.	
	In the event for corrective actions the Director of Nursing, Assistant Director of Nursing and/or Administrator will conduct a full investigation of each fall for residents #1, #3, #4, #5 and all residents with potential falls.	
	Each fall will be updated in the residents care plan by the MDS coordinator.	
	Each Care plan will be updated with interventions consistent with the reason or cause of the residents fall.	
	Each event will be fully completed with all documentations, how the fall happened, intervention put into place, and if the	

	intervention was successfully executed or not.	
	Progress notes will be completed and staff will be notified through Care plans and in-serviced of interventions and any programs implemented to prevent future falls..	
	The Director of Nursing will in-service all staff on new fall protocols and programs. This in-service will be completed on or prior to 4/8/25/	
	Each fall, intervention, and outcome will be monitored by the ADON, DON, and or Administrator and will be discussed in each monthly QAPI meeting with ID.	
A 4077	19CSR 30-85.042(68) Resident Groomed/Dressed Appropriately	4/10/2025
F561	Self- Determination	
	This requirement was not met by the facility due to the facilities failure to promote each resident right to self-determination when the facility failed to complete shower/bathing requirement to meet each resident preference. Facility failed to documents offered/refused/provided showers.	
	In the event for corrective action, the Director of Nursing and Assistant Director of nursing will In-service all nursing staff on rights to self – determinations on or before 4/8/25.	
	The DON and ADON will ensure that residents #1, #2, and all other residents are offered 2 showers per week and POC documentation is completed on each resident.	
	The DON and ADON will ensure that all documentation is completed an uploaded for all given and/or refused showers.	
	The DON and ADON will ensure there are progress notes created for each refused shower.	
	All showers will be monitored by the Administrator and discussed in QAPI each month with IDT team.	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.